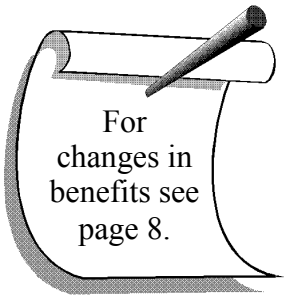
PersonalCare's HMO

http://www.personalcarehmo.com

PersonalCare

2002

A Health Maintenance Organization



Serving: Central Illinois

Enrollment in this plan is limited; You must live in or work in our geographic area to enroll. See page 7 for requirements.

Commercial HMO

This Plan has Excellent Accreditation from NCQA. See the *2002 Guide* for more information on accreditation.

Special Notice: We eliminated part of our service area for 2002. If you are enrolled in this plan and live in Clark, Cumberland, or Crawford counties in Illinois, you must select another plan during the Open Season to continue to receive full benefits. If you live in one of these areas and you do not select another FEHB Program Plan, you must travel to a county in our remaining service area to receive Plan benefits.

Enrollment codes for this Plan:

GE1 Self Only
GE2 Self and Family

Authorized for distribution by the:

United States
Office of Personnel Management
Retirement and Insurance Service
http://www.opm.gov/insure

FEHB
Federal Employees
Health Benefits Program

RI 73-257

Notes

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Introduction

PersonalCare's HMO, 2110 Fox Drive, Champaign, IL 61820

This brochure describes the benefits of PersonalCare's HMO under our contract (CS2042) with the Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits (FEHB) law. This brochure is the official statement of benefits. No oral statement can modify or otherwise affect the benefits, limitations and exclusions of this brochure.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled for Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2002, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2002, and changes are shown on page 8. Rates are shown at the end of this brochure.

Plain language

Teams of Government and health plans' staff worked on all FEHB brochures to make them responsive, accessible, and understandable to the public. For instance,

- Except for necessary technical terms, we use common words. For instance, "you" means the enrollee or family member; "we" means PersonalCare.
- We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the Office of Personnel Management. If we use others, we tell you what they mean first.
- Our brochure and other FEHB plans' brochures have the same format and similar descriptions to help you compare plans.

If you have comments or suggestions about how to improve the structure of this brochure, let us know. Visit OPM's "Rate Us" feedback area at www.opm.gov/insure or e-mail us at fehbwebcomments@opm.gov.

Inspector General Advisory

Stop health care fraud!

Fraud increases the cost of health care for everyone. If you suspect that a physician, pharmacy, or hospital has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:

- Call the provider and ask for an explanation. There may be an error.
- If the provider does not resolve the matter, call us at 800/431-1211 and explain the situation.
- If we do not resolve the issue, call or write

THE HEALTH CARE FRAUD HOTLINE
202/418-3300
The United States Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street, NW, Room 6400
Washington, DC 20415

Penalties for Fraud

Anyone who falsifies a claim to obtain FEHB Program benefits can be prosecuted for fraud. Also, the Inspector General may investigate anyone who uses an ID card if the person tries to obtain services for someone who is not an eligible family member, or is no longer enrolled in the Plan and tries to obtain benefits. Your agency may also take administrative action against you.

Section 1. Facts about this HMO plan

This Plan is a health maintenance organization (HMO). We require you to see specific physicians, hospitals and other providers that contract with us. These Plan providers coordinate your health care services.

HMOs emphasize preventive care such as routine office visits, physical exams, well-baby care and immunizations, in addition to treatment for illness and injury. Our providers follow generally accepted medical practice when prescribing any course of treatment.

When you receive services from Plan providers, you will not have to submit claim forms or pay bills. You only pay the copayments and coinsurance listed in this brochure. When you receive emergency services from non-Plan providers, you may have to submit claim forms.

You should join an HMO because you prefer the plan's benefits, not because a particular provider is available. You cannot change plans because a provider leaves our Plan. We cannot guarantee that any one physician, hospital, or other provider will be available and/or remain under contract with us.

How we pay providers

We contract with individual physicians, medical groups, and hospitals to provide the benefits in this brochure. These Plan providers accept a negotiated payment from us, and you will only be responsible for your copayments or coinsurance.

Your Rights

OPM requires that all FEHB Plans provide certain information to their FEHB members. You may get information about us, our networks, providers, and facilities. OPM's FEHB website (www.opm.gov/insure) lists the specific types of information that we must make available to you. Some of the required information is listed below.

PersonalCare's HMO is a prepaid health plan (mixed model) that contracts with medical groups and individual doctors in Champaign, Danville, Kankakee, Springfield and many other central Illinois communities. You may contact PersonalCare for assistance in choosing the most conveniently located doctors. Members may change chosen doctors upon request by contacting PersonalCare at 217/366-1226 or 800/431-1211.

A primary care doctor may refer you to any network specialist, regardless of location or group affiliation.

If you want specific information about us, call (800) 431-1211, or write to 2110 Fox Drive, Champaign, IL 61820. You may also contact us by fax at (217) 366-5410, or visit our Web site at www.personalcarehmo.com.

Service Area

To enroll in this Plan, you must live in or work in our Service Area. This is where our providers practice. Our service area is the Illinois counties of Champaign, Christian, Coles, DeWitt, Douglas, Edgar, Ford, Iroquois, Kankakee, Logan, Macon, Menard, Morgan, Moultrie, Piatt, Sangamon, Shelby and Vermilion.

Ordinarily, you must get your care from providers who contract with us. If you receive care outside our service area, we will pay only for emergency care. We will not pay for any other health care services out of our service area unless the services have prior approval.

If you or a covered family member move outside of our service area, you can enroll in another plan. If your dependents live out of the area (for example, if your child goes to college in another state), you should consider enrolling in a fee-for-service plan or an HMO that has agreements with affiliates in other areas. If you or a family member move, you do not have to wait until Open Season to change plans. Contact your employing or retirement office.

Section 2. How we change for 2002

Do not rely on these change descriptions; this page is not an official statement of benefits. For that, go to Section 5 Benefits. Also, we edited and clarified language throughout the brochure; any language change not shown here is a clarification that does not change benefits.

Program-wide changes

- We removed the requirement that services must be needed to restore functional speech from the speech therapy benefit (Section 5(a)).

Changes to this Plan

- Your share of the non-Postal premium will increase by 15.2 % for Self Only or 15.3 % for Self and Family.
- We clarified the Preventive care, adult benefits by removing the entry for blood lead level testing for adults because it is a test more typically done for children
- We clarified the brochure to show why we think you should use generic drugs whenever possible. We moved other language around within the Prescription drugs section but didn't change its meaning.
- We clarified Surgical procedures to show that we cover a comprehensive range of services, such as operative procedures.
- Your emergency room copayment has increased to $100 or 50% of charges, whichever is less, from $50 or 50% of charges, whichever is less.
- Your Durable Medical Equipment benefit is no longer limited to initial equipment only.
- PersonalCare is no longer offered in the counties of Clark, Cumberland and Crawford.
- We now cover certain intestinal transplants (Section 5(b).

Section 3. How you get care

Identification cards

We will send you an identification (ID) card when you enroll. You should carry your ID card with you at all times. You must show it whenever you receive services from a plan provider, or fill a prescription at a Plan pharmacy. Until you receive your ID card, use your copy of the Health Benefits Election Form, SF-2809, your health benefits enrollment confirmation (for annuitants), or your Employee Express confirmation letter.

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at (800) 431-1211.

Where you get covered care

You get care from Plan providers and Plan facilities. You will only pay copayments and/or coinsurance, and you will not have to file claims.

- **Plan providers**

Plan providers are physicians and other health care professional in our service area that we contract with to provide covered services to our members. We credential Plan providers according to national standards.

We list Plan providers in the provider directory, which we update periodically. The list is also on our Web site.

- **Plan facilities**

Plan facilities are hospitals and other facilities in our service area that we contract with to provide covered services to our members. We list these in the provider directory, which we update periodically. The list is also on our Web site.

What you must do to get covered care

It depends on the type of care you need. First, you and each family member must choose a primary care physician. This decision is important since your primary care physician provides or arranges for most of your health care. These doctors are listed in your provider directory, and you may call our customer service department at (800) 431-1211 to tell us what doctor you choose.

- **Primary care**

Your primary care physician can be any type of physician listed under the heading "Primary Care Practitioner" in your provider directory. Your primary care physician will provide most of your health care, or give you a referral to see a specialist.

If you want to change primary care physicians or if your primary care physician leaves the Plan, call us. We will help you select a new one.

- **Specialty care**

Your primary care physician will refer you to a specialist for needed care. When you receive a referral from your primary care physician, you must return to the primary care physician after the consultation, unless your primary care physician authorized a certain number of visits without additional referrals. The primary care physician must provide or authorize all follow-up care. Do not go to the specialist for return visits unless your primary care physician gives you a referral. However, female members may see their woman's principal health care provider without a referral.

Here are other things you should know about specialty care:

- If you need to see a specialist frequently because of a chronic, complex, or serious medical condition, your primary care physician will develop a treatment plan that allows you to see your specialist for a certain number of visits without additional referrals. Your primary care physician will use our criteria when creating your treatment plan (the physician may have to get an authorization or approval beforehand).
- If you are seeing a specialist when you enroll in our Plan, talk to your primary care physician. Your primary care physician will decide what treatment you need. If he or she decides to refer you to a specialist, ask if you can see your current specialist. If your current specialist does not participate with us, you must receive treatment from a specialist who does. Generally, we will not pay for you to see a specialist who does not participate with our Plan.
- If you are seeing a specialist and your specialist leaves the Plan, call your primary care physician, who will arrange for you to see another specialist. You may receive services from your current specialist until we can make arrangements for you to see someone else.
- If you have a chronic or disabling condition and lose access to your specialist because we:
  - terminate our contract with your specialist for other than cause; or
  - drop out of the FEHB Program and you enroll in another FEHB Plan; or
  - reduce our service area and you enroll in another FEHB Plan,

  you may be able to continue seeing your specialist for up to 90 days after you receive notice of the change. Contact us or, if we drop out of the Program, contact your new plan.

  If you are in the second or third trimester of pregnancy and you lose access to your specialist based on the above circumstances, you can continue to see your specialist until the end of your postpartum care, even if it is beyond the 90 days.

- **Hospital care**

Your Plan primary care physician or specialist will make necessary hospital arrangements and supervise your care. This includes admission to a skilled nursing or other type of facility.

If you are in the hospital when your enrollment in our Plan begins, call our customer service department at 800/431-1211. If you are new to the FEHB Program, we will arrange for you to receive care.

If you changed from another FEHB plan to us, your former plan will pay for the hospital stay until:

- You are discharged, not merely moved to an alternative care center, or
- The day your benefits from your former plan run out, or
- The 92nd day after you became a member of this Plan; whichever happens first.

These provisions only apply to the benefits of the hospitalized person.

Circumstances beyond our control

Under certain extraordinary circumstances, we may have to delay your services or be unable to provide them. In that case, we will make all reasonable efforts to provide you with necessary care.

Services requiring our prior approval

Your primary care physician has authority to refer you for most services. For certain services, however, your physician must get our approval. Before giving approval, we consider if the service is medically necessary, and if it follows generally accepted medical practice.

Your physician must obtain approval for the following services:

- Out of network referral
- Home health
- Hospice
- In-home infusion therapy
- Hospital admission to out-of-network hospital
- Mental health treatment, inpatient only
- Substance abuse treatment
- Non-emergency ambulance transport
- Infertility services
- Placement in a nursing home, intermediate care facility, or other assisted care setting
- Outpatient rehabilitative services such as: physical therapy and occupational therapy
- Respiratory therapy.
- Speech therapy
- Chiropractic
- Cardiac or pulmonary rehabilitation
- Sterilization
- Hysterectomy
- Reconstructive surgery
- Durable medical equipment, prosthetic devices
- Transplants
- Some medications

Section 4. Your costs for covered services

You must share the cost of some services. You are responsible for:

- **Copayments**

  A copayment is a fixed amount of money you pay to the provider, facility, pharmacy, etc., when you receive services.

  Example: When you see your primary care physician you pay a copayment of $10 per office visit and when you go to the hospital, you pay $100 per admission.

- **Deductibles**

  A deductible is a fixed expense you must incur for covered services and supplies before you receive benefits for them. We do not have a deductible.

- **Coinsurance**

  Coinsurance is the percentage of our negotiated fee that you must pay for your care.

  Example: In our Plan, you pay 20% of our allowance for durable medical equipment, prosthetic devices, and orthopedic devices.

Your out-of-pocket maximum for coinsurance and copayments

After your copayments total $1,500 per person or $3,000 per family enrollment in any calendar year, you do not have to pay any more for covered services. However, copayments or coinsurance for the following services do not count toward you out-of-pocket maximum, and you must continue to pay for these services:

- Prescription drugs
- Durable medical equipment and prosthetic devices
- Vision screening
- Prescribed injectables

Be sure to keep accurate records of your copayments and coinsurance since you are responsible for informing us when you reach the maximum.

Section 5. Benefits – Overview

(See page 8 for how our benefits changed this year and page 51 for a benefits summary.)

Note: This benefits section is divided into subsections. Please read the important things you should keep in mind at the beginning of each subsection. Also read the General Exclusions in Section 6; they apply to the benefits in the following subsections. To obtain claims forms, claims filing advice, or more information about our benefits, contact us at (800) 431-1211 or at our Web site at www.personalcarehmo.com.

Section 5(a). Medical services and supplies provided by physicians and other health care professionals

IMPORTANT

Here are some important things to keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- We have no calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

Benefit Description	You pay
Diagnostic and treatment services	
Professional services of physicians • In the physician's office	$10 per office visit
Professional services of physicians • In an urgent care center • In a skilled nursing facility • Office medical consultation • Second surgical opinion	$10 per office visit
Professional services of physicians • At home • During a hospital stay	Nothing
Not covered: • *Physical examinations that are not necessary for medical reasons, such as those required for obtaining or continuing employment or insurance, attending school or camp, or travel* • *Blood and blood derivatives not replaced by the member*	*All charges*

Lab, X-ray and other diagnostic tests	You pay
Tests, such as: • Blood tests • Urinalysis • Non-routine Pap tests • Pathology • X-rays • Non-routine mammograms • Cat scans/MRI • Ultrasound • Electrocardiogram and EEG	Nothing
Preventive care, adult	
Routine preventive exam	$10 per office visit
Routine screenings, such as: • Total blood cholesterol, once every five years • Colorectal cancer screening, including: •• Fecal occult blood test, every 3 to 5 years, age 50 and older •• Sigmoidoscopy screening, every 3 to 5 years, age 50 and older • Pelvic exam and Pap smear, every 1 to 3 years, female members age 18 and older • Routine mammogram –covered for women age 35 and older, as follows: ••From age 35 through 39, one during this five year period ••From age 40 through 64, one every calendar year ••At age 65 and older, one every two consecutive calendar years • Prostate Specific Antigen (PSA test), one annually for men age 40 and older	Nothing if you receive these services during your office visit; otherwise $10 per visit
Routine immunizations, limited to: • Tetanus-diptheria (Td) booster - once every 10 years, age 18 and older • Influenza •• Every year if high risk, age 18 and older •• Every year, age 65 and older • Pneumococcal •• 1 dose if susceptible/high risk, ages 18 to 65 •• 1 dose, age 65, may repeat in 5 years • Hepatitis B, 3 doses if medical high risk, age 18 and older	Nothing if you receive these services during your office visit; otherwise $10 per visit
Preventive care, children	**You pay**
• Childhood immunizations recommended by the American Academy of Pediatrics	Nothing if you receive these services during your office visit

• Examinations such as: •• Vision screening through age 17 to determine the need for vision correction •• Hearing screenings through age 17 to determine the need for hearing correction •• Examinations done on the day of immunizations •• Routine preventive examinations and care, age 1 and older	$10 per office visit
Well-baby examinations and care up to age 1	Nothing

Maternity care	
Complete maternity care, such as: • Prenatal care • Delivery • Postnatal care Note: Here are some things to keep in mind: • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother's hospital stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. • We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b).	Nothing for office visits; $100 copay for hospital admission
Not covered • *Routine sonograms to determine fetal age, size or sex.*	*All charges*

Family planning	
A broad range of voluntary family planning services, such as: • Voluntary sterilization • Injectable contraceptive drugs and contraceptive devices Note: We cover injectable fertility drugs under medical benefits and oral fertility drugs under the prescription drug benefit	$10 per office visit
Not covered • *Reversal of voluntary surgical sterilization* • *Genetic counseling*	*All charges*

Infertility services	**You pay**
Diagnosis and treatment of infertility	$10 per office visit

Not covered • *Assisted reproductive technology (ART) procedures, such as:* *- In vitro fertilization* *- Embryo transfer, gamete GIFT and zygote ZIFT* *- Zygote transfer* • *Cost of donor sperm* • *Cost of donor egg*	*All charges*
Allergy care	
Testing and treatment Allergy injection Allergy serum	Nothing
Not covered • *Provocative food testing* • *Sublingual allergy desensitization*	*All charges*
Treatment therapies	
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants are limited to those transplants listed under Organ/Tissue Transplants on page 22. • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – home IV and antibiotic therapy	Nothing
• Growth hormone therapy (GHT) Note: We only cover GHT when we preauthorize the treatment. Your primary care physician or referral specialist will arrange for authorization. We must authorize GHT before you begin treatment; we will not cover unauthorized treatments. Note: Growth hormone is covered under the prescription drug benefit.	50% of charges
Physical and occupational therapies	**You pay**
Up to two consecutive months per condition for the services of each of the following: — Qualified physical therapists; and — Occupational therapists Note: We only cover therapy to restore bodily function when there has been a total or partial loss of bodily function due to illness or injury. [Occupational therapy is limited to services that assist the member to achieve and maintain self-care and improved functioning in other activities of daily living.]	$10 per office visit Nothing per visit during covered inpatient admission

• Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction is provided for up to two months per condition if significant improvement can be expected within two months.	Nothing
Not covered • *Long term rehabilitative therapy* • *Exercise programs*	*All charges*
Speech therapy	
• Up to two consecutive months per condition	$10 per office visit Nothing per visit during covered inpatient admission
Hearing services (testing, treatment and supplies)	
• Hearing screening, 1 every year • First hearing aid and testing only when necessitated by accidental injury • Hearing testing for children through age 17 (*see Preventive care, children*)	$10 per office visit
Not covered • *All other hearing testing* • *Hearing aids, testing and examinations for them, other than those described above.*	*All charges*
Vision services (testing, treatment, and supplies)	
• Eye refractions for all members (to provide a written lens prescription for eyeglasses) may be obtained through Cole Vision's Vision One Exam Plus® Program. Cole Vision has a large network of providers in the optical departments of major retailers such as Sears, JC Penney, and participating Pearle Vision Centers. Call (800) 799-0259 to find the provider nearest you. Cole Vision also has a discount program for frames and lenses.	$30 per office visit
Vision services (testing, treatment, and supplies)	**You pay**
• One pair of lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts); we do not cover frames.	Nothing
Not covered • *The fitting of contact lenses* • *Eye exercises* • *Radial keratotomy and other refractive surgery*	*All charges*

Foot care	
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes	$10 per office visit
Not covered • *Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above.* • *Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)*	*All charges*
Orthopedic and prosthetic devices	
• Artificial limbs and eyes; stump hose • Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy • Internal prosthetic devices, such as pacemakers and artificial joints, cochlear implants, and surgically implanted breast implant following mastectomy. Note: We pay internal prosthetic devices as hospital benefits; see Section 5(c) for payment information. See 5b for coverage of the surgery to insert the device. • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome	20% of charges

Orthopedic and prosthetic devices (*Continued*)	
Not covered • *Orthopedic and corrective shoes* • *Arch supports* • *Foot orthotics* • *Heel pads and heel cups* • *Lumbosacral supports* • *Corsets, trusses, elastic stockings, support hose, and other supportive devices*	*All charges*

Durable medical equipment (DME)	You pay
Rental or purchase, at our option, including repair and adjustment, of durable medical equipment prescribed by your Plan physician, such as oxygen and dialysis equipment. Under this benefit, we also cover: • Wheelchairs • Hospital beds • Crutches • Walkers • Blood glucose monitors, Medisense Precision QID only • Insulin pumps	20% of charges
Not covered • *Motorized wheelchairs*	*All charges*

Home health services	
Home health care ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide. Your Plan physician will periodically review the program for continuing appropriateness and need. Services include oxygen therapy, intravenous therapy and medications. Note: You must receive prior approval for these services. See Section 3 for services requiring prior approval.	Nothing
Not covered • *Nursing care requested by, or for the convenience of, the patient or the patient's family* • *Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative*	*All charges*

Chiropractic	
• Manipulation of the spine and extremities • Adjunctive procedures such as ultrasound, electrical muscle stimulation, vibratory therapy, and cold pack application Note: You must receive prior approval for these services. See Section 3 for services requiring prior approval.	$10 per office visit
Alternative treatments	
Acupuncture, by a doctor of medicine or osteopathy for anesthesia or pain relief. Note: You must receive prior approval for these services. See Section 3 for services requiring prior approval.	$10 per office visit
Not covered: • *naturopathic services* • *hypnotherapy* • *biofeedback*	*All charges*
Educational classes and programs	
Coverage is limited to: • Diabetes self-management training and education	$10 per office visit

Section 5 (b) Surgical and anesthesia services provided by physicians and other health care professionals

IMPORTANT

Here are some important things to keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- We have no calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. Look in Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.).

IMPORTANT

Benefit Description	You pay
Surgical procedures	
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Normal pre-and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see reconstructive surgery) • Surgical treatment of morbid obesity, a condition in which an individual weighs 100 pounds or 100% over his or her normal weight according to current underwriting standards; eligible members must be age 18 or over • Insertion of internal prosthetic devices. See Section 5(a) Orthopedic and prosthetic devices for device coverage information • Voluntary sterilization • Treatment of burns Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker.	Nothing
Not covered • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot; see Foot care* • *Surgery primarily for cosmetic purposes*	*All charges*

Reconstructive surgery	You pay
• Surgery to correct a functional defect • Surgery to correct a condition caused by an injury or illness if: — the condition produced a major effect on the member's appearance and — the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are protruding ear deformities; cleft lip; cleft palate; birth marks; webbed fingers; and webbed toes. • All stages of breast reconstruction surgery following a mastectomy, such as: — surgery to produce a symmetrical appearance on the other breast — treatment of any physical complications, such as lymphedemas; — breast prostheses and surgical bras and replacements (see Prosthetic devices) Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.	Nothing
Not covered • *Cosmetic surgery, any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury* • *Surgeries related to sex transformations*	*All charges*
Oral and maxillofacial surgery	
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones • Surgical correction of cleft lip, cleft palate or severe functional malocclusion • Removal of stones from salivary ducts • Excision of leukoplakia or malignancies • Excision of cysts and incision of abscesses when done as an independent procedure; and • Other surgical procedures that do not involve the teeth or their supporting structures	Nothing
Not covered • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva and alveolar bone)*	*All charges*

Organ/tissue transplants	You pay
Limited to: • Cornea • Heart • Heart/lung • Lung (single or double) • Pancreas • Kidney/pancreas • Kidney • Liver • Allogeneic (donor) bone marrow transplants • Autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) for the following conditions: acute lymphocytic or non-lymphocytic leukemia; advanced Hodgkin's lymphoma; advanced non-Hodgkin's lymphoma; advanced neuroblastoma; breast cancer; multiple myeloma; epithelial ovarian cancer; and testicular, mediastinal, retroperitoneal and ovarian germ cell tumors • Intestinal transplants (small intestine) and the small intestine with the liver or small intestine with multiple organs such as liver, stomach, and pancreas Limited benefits: Treatment for breast cancer, multiple myeloma, and epithelial ovarian cancer may be provided in an NCI- or NIH-approved clinical trial at a Plan-designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocols. Note: We cover related medical and hospital expenses of the donor when we cover the recipient.	Nothing
Not covered • *Donor screening tests and donor search expenses, except those performed for the actual donor* • *Implants of artificial organs* • *Transplants not listed as covered*	*All charges*
Anesthesia	
Professional services provided in : • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office	Nothing

Section 5(c) Services provided by a hospital or other facility, and ambulance services

IMPORTANT

Here are some important things to remember about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care and you must be hospitalized in a plan facility.
- We have no calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e., physicians etc.) are covered in Sections 5(a) or (b).

IMPORTANT

Benefit Description	You pay
Inpatient hospital	
Room and board, such as • Ward, semiprivate, or intensive care accommodations • General nursing care • Meals and special diets Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	$100 per inpatient admission
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Administration of blood and blood products • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home	Nothing
Not covered • *Custodial care* • *Non-covered facilities, such as nursing homes and schools* • *Personal comfort items, such as telephone, television, barber services, guest meals and beds* • *Private nursing care* • *Blood and blood derivatives not replaced by the member*	*All charges*

Outpatient hospital or ambulatory surgery center	You pay
• Operating, recovery and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays, and pathology services • Administration of blood and blood products • Presurgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia services Note: We cover hospital services and supplies related to dental procedures when necessitated by a nondental physical impairment. We do not cover dental procedures.	Nothing
Not covered • *Blood and blood derivatives not replaced by the member*	*All charges*
Extended care benefits/skilled nursing care facility benefits	
Skilled nursing facility (SNF), up to 120 days per calendar year • Bed, board and general nursing care • Drugs, biologicals, supplies, and equipment ordinarily provided or arranged by the skilled nursing facility when prescribed by a Plan doctor.	Nothing
Not covered • *Custodial care*	*All charges*
Hospice care	
Supportive and palliative care for a terminally ill member in the home or hospice facility provided under the direction of a Plan doctor who certifies that the patient is in the terminal stages of illness, with a life expectancy of approximately six months or less. Services include: • Inpatient and outpatient care • Family counseling	Nothing
Not covered • *Independent nursing* • *Homemaker services*	*All charges*
Ambulance	
• Local professional ambulance service when medically appropriate	Nothing

Section 5(d) Emergency services/accidents

IMPORTANT

Here are some important things to remember about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure.
- We have no calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

What is a medical emergency?

A medical emergency is the sudden and unexpected onset of a condition or an injury that you believe endangers your life or could result in serious injury or disability, and requires immediate medical or surgical care. Some problems are emergencies because, if not treated promptly, they might become more serious; examples include deep cuts and broken bones. Others are emergencies because they are potentially life threatening, such as heart attacks, strokes, poisonings, gunshot wounds, or sudden inability to breathe. There are many other acute conditions that the Plan may determine are medical emergencies—what they all have in common is the need for quick action.

What to do in case of emergency:

When we decide what conditions are true emergencies, we think about what a person with average knowledge of health and medicine would do. If that person would reasonably believe that the condition is life-threatening or disabling, then we consider it an emergency.

If you have a true emergency, you should go immediately to a hospital emergency department. You should go to a PersonalCare network hospital, unless a delay in going to that hospital would endanger your life or health. You should tell the hospital staff who your PCP is.

If the symptoms are not immediately threatening to your life or health, you should call your PCP to find out if you should go to the emergency department or to his or her office. PersonalCare will not pay for emergency department visits that are not true emergencies. We also will not pay for emergency department visits related to conditions not covered by your plan.

Emergencies within the service area

If you are in an emergency situation, please call your primary care doctor. In extreme emergencies, if you are unable to contact your doctor, contact the local emergency system (e.g., the 911 telephone system) or go to the nearest hospital emergency room. You should go to a PersonalCare network hospital, unless a delay in going to that hospital would endanger your life or health. Be sure to tell the emergency room personnel that you are a Plan member and who your PCP is. You or a family member should notify your PCP within 48 hours.

If you need to be hospitalized in a non-Plan facility, the Plan must be notified within 48 hours or on the first working day following your admission, unless it was not reasonably possible to notify the Plan within that time. If you are hospitalized in non-Plan facilities and Plan doctors believe care can be better provided in a Plan hospital, you will be transferred when medically feasible with any ambulance charges covered in full.

Benefits are available for care from non-Plan providers in a medical emergency only if delay in reaching a Plan provider would result in death, disability or significant jeopardy to your condition.

To be covered by this Plan, any follow-up care recommended by non-Plan providers must be approved by the Plan or provided by Plan providers.

Emergencies outside the service area

Benefits are available for any medically necessary health service that is immediately required because of injury or unforeseen illness.

If you need to be hospitalized, the Plan must be notified within 48 hours or on the first working day following your admission, unless it was not reasonably possible to notify the Plan within that time. If a Plan doctor believes care can be better provided in a Plan hospital, you will be transferred when medically feasible with any ambulance charges covered in full.

To be covered by this Plan, any follow-up care recommended by non-Plan providers must be approved by the Plan or provided by Plan providers.

Benefit Description	You pay
Emergency within our service area	
Emergency care at a doctor's office Emergency care at an urgent care center	$10 per office visit
Emergency care as an outpatient at a hospital emergency department, including doctors' services Note: Charges for an emergency department visit are waived if you are admitted as an inpatient within 48 hours for the same condition	$100 or 50%, whichever is less
Not covered • *Elective care or nonemergency care*	*All charges*

Emergency outside our service area	You pay
Emergency care at a doctor's office Emergency care at an urgent care center	$10 per visit
Emergency care as an outpatient at a hospital emergency department, including doctors' services Note: Charges for an emergency department visit are waived if you are admitted as an inpatient within 48 hours for the same condition	$100 or 50%, whichever is less
Not covered • *Elective care or nonemergency care* • *Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area* • *Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area*	*All charges*
Ambulance	
Professional ambulance service when medically appropriate. See Section 5(c) for nonemergency service.	Nothing
Not covered • *Air ambulance*	*All charges*

Section 5(e) Mental health and substance abuse benefits

IMPORTANT

When you get our approval for services and follow a treatment plan we approve, cost-sharing and limitations for Plan mental health and substance abuse benefits will be no greater than for similar benefits for other illnesses and conditions.

Here are some important things to remember about these benefits:

- All benefits are subject to the definitions, limitations, and exclusions in this brochure.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **YOU MUST GET PREAUTHORIZATION FOR THESE SERVICES.** See the instructions after the benefits description below.

IMPORTANT

Benefit Description	You pay
Mental health and substance abuse benefits	
All diagnostic and treatment services recommended by a Plan provider and contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure. Note: Plan benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.	Your cost sharing responsibilities are no greater than for other illness or conditions.
• Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers • Medication management	$10 per office visit
• Services in approved alternative care setting such as partial hospitalization or facility based intensive outpatient treatment	$10 per visit
• Diagnostic tests	Nothing
• Services provided by a hospital or other facility • Services in approved alternative care settings such as half-way house, residential treatment	$100 per inpatient admission
Not covered: • *Services we have not approved.* • *Psychiatric evaluation or therapy on court order or as a condition of parole or probation, unless determined by a Plan doctor to be necessary and appropriate* *Note: OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.*	*All charges*

Mental health and substance abuse benefits (*continued)*	You pay

Preauthorization

To be eligible to receive these benefits you must obtain a treatment plan and follow all of the following authorization processes:

Members must have a referral from their PCP to see a mental health specialist or to receive substance abuse services.

Your PCP will arrange for PersonalCare's authorization of services when necessary.

A listing of mental health providers is in our provider directory. You will find it on our Web site at www.personalcarehmo.com or you may call (800) 431-1211 for a directory.

Limitations

We may limit your benefits if you do not obtain a treatment plan.

Section 5(f) Prescription drug benefits

IMPORTANT	**Here are some important things to keep in mind about these benefits:** • We cover prescribed drugs and medications, as described in the chart beginning on the next page and are payable only when we determine they are medically necessary. • All benefits are subject to the definitions, limitations, and exclusions in this brochure. • We have no calendar year deductible. • Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.	IMPORTANT

There are important features you should be aware of. These include:

- **Who can write your prescription.** A licensed physician must write the prescription.
- **Where you can obtain them.** You must fill the prescription at a plan pharmacy.
- **We use a formulary (preferred drug list).** PersonalCare's physician committee has developed the preferred drug list. This list includes high quality drugs to treat medical conditions. A physician committee reviews the list often to make sure that the best drugs are included. Your doctor may prescribe drugs not on the list. You will pay a higher copayment for drugs not on the preferred list. Some drugs will not be on the list because PersonalCare does not cover them or because other drugs work better. A few drugs need approval from PersonalCare before your doctor can prescribe them. Your doctor will take care of this for you. You can get a copy of our preferred drug list by calling PersonalCare Customer Service at (800) 431-1211. You will also find the formulary listing on our Web site at www.personalcarehmo.com.
- **These are the dispensing limitations.** For most drugs, you will pay one copayment for each 100 units or 30-day supply, whichever is less. You pay this at the pharmacy when you have the prescription filled. Prepackaged medications (such as inhalers, ophthalmic solutions, topical creams) require one copayment per package. If your doctor prescribes a nonpreferred drug, your copayment will be higher for each 30-day supply, or each prepackaged unit. Your pharmacy will give you a generic drug if one is available and if your doctor allows a generic substitution. You pay only a $5 copayment for these drugs. When there is no generic, you will get the preferred ($15 copayment) or nonpreferred ($35 copayment) brand name. Important: If a generic drug is available to you, and you or your doctor ask for a name brand drug instead of the generic, you will pay the $5 generic copayment plus the difference in retail price between the generic drug and the name brand drug.
- **Why use generic drugs?** Generic drugs contain the same active ingredients and are equivalent in strength and dosage to the original brand name product. Generic drugs cost you and your plan less money than a name-brand drug.
- **When you have to file a claim.** PersonalCare has a national network of pharmacies, and you will not have to file a claim if you fill your prescriptions at any of these pharmacies. If you need a prescription filled in an emergency when you are out of the service area, or your regular pharmacy is closed, and you can not locate a network pharmacy, go to the nearest open pharmacy. Please send the cash receipt and the reason that this was an emergency to PersonalCare. We will reimburse you for the prescription, less your copayment, in true emergency situations.□

Benefit Description	You pay
Covered medications and supplies	
We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy: • Drugs for which a prescription is required by law • Insulin, with a copay charge applied to each vial • Diabetic supplies including insulin syringes, needles, glucose test tablets and test tape, Benedict's solution or equivalent and acetone test tablets • Disposable needles and syringes needed to inject covered prescribed medication • Drugs for sexual dysfunction, with dispensing limitations. Contact the Plan for details • Oral fertility drugs • Contraceptive drugs and devices Note: Intravenous fluids and medication for home use, implantable drugs, and some injectable drugs are covered under Medical and Surgical Benefits	$5 copay for generic drugs $15 copay for name brand preferred drugs $35 copay for name brand nonpreferred drugs Note: If there is no generic equivalent available, you will still have to pay the name brand copay.
Not covered • *Drugs or supplies for cosmetic purposes* • *Drugs to enhance athletic performance* • *Vitamins and nutritional substances that can be purchased without a prescription* • *Drugs obtained at non-Plan pharmacies, except for out-of-area emergencies* • *Nonprescription medicines*	*All charges*

Section 5(g). Special features

Feature	Description
Centers of excellence for transplants	PersonalCare uses the transplant facilities of the United Resource Network (URN). URN contracts only with major medical centers selected according to standards and criteria established by the International Society of Transplant Surgeons. These providers are available only with a referral from you primary care physician and authorization from PersonalCare.

Section 5(h). Dental benefits

IMPORTANT

Here are some important things to keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- We have no calendar year deductible.
- We cover hospitalization for dental procedures only when a nondental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient; we do not cover the dental procedure unless it is described below.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

Accidental injury benefit	You Pay
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth due to traumatic injury within thirty (30) days of the injury. The need for these services must result from an accidental injury.	Nothing
Dental benefits	
We have no other dental benefits	

Notes

Section 6. General exclusions – things we don't cover

The exclusions in this section apply to all benefits. A**lthough we may list a specific service as a benefit, we will not cover it unless your Plan doctor determines it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition.**

We do not cover the following:

- Care by non-Plan providers except for authorized referrals or emergencies (see Emergency Benefits);
- Services, drugs or supplies you receive while you are not enrolled in this Plan;
- Services, drugs or supplies that are not medically necessary;
- Services, drugs or supplies not required according to accepted standards of medical, dental, or psychiatric practice;
- Experimental or investigational procedures, treatments, drugs or devices;
- Services, drugs or supplies related to abortions except when the life of the mother would be endangered if the fetus were carried to term or when the pregnancy is the result of an act of rape or incest;
- Services, drugs or supplies related to sex transformations; or
- Services, drugs or supplies you receive from a provider or facility barred from the FEHB Program.

Section 7. Filing a claim for covered services

When you see Plan physicians, receive services at Plan hospitals and facilities, or obtain your prescription drugs at Plan pharmacies, you will not have to file claims. Just present your identification card and pay your copayment or coinsurance.

You will only need to file a claim when you receive emergency services from nonplan providers. Sometimes these providers bill us directly. Check with the provider. If you need to file the claim, here is the process:

Medical, hospital and drug benefits

In most cases, providers and facilities file claims for you. Physicians must file on the form HCFA-1500, Health Insurance Claim Form. Facilities will file on the UB-92 form. For claims questions and assistance, call us at (800) 431-1211.

When you must file a claim—such as for out-of-area care—submit it on the HCFA-1500 or a claim form that includes the information shown below. Bills and receipts must be itemized and show:

- Covered member's name and ID number
- Name and address of the physician or facility that provided the service or supply;
- Dates you received the services or supplies;
- Diagnosis;
- Type of each service or supply;
- The charge for each service or supply;
- A copy of the explanation of benefits, payments or denial from any primary payer, such as the Medicare Summary Notice (MSN); and
- Receipts, if you paid for your services.

Submit your claims to 2110 Fox Drive, Champaign, IL 61820.

Deadline for filing your claim

Send us all the documents for your claim as soon as possible. You must submit the claim by December 31 of the year after the year you received the service, unless timely filing was prevented by administrative operations of Government or legal incapacity, provided the claim was submitted as soon as reasonably possible.

When we need more information

Please reply promptly when we ask for additional information. We may delay processing or deny your claim if you do not respond.

Section 8. The disputed claims process

Follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your claim or request for services, drugs, or supplies—including a request for preauthorization:

Step	Description
1	Ask us in writing to reconsider our initial decision. You must: a) Write to us within 6 months from the date of our decision; and b) Send your request to us at 2110 Fox Drive, Champaign, IL 61820; and c) Include a statement explaining why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and d) Include copies of documents that support your claim, such as physician's letters, operative reports, bills, medical records, and explanations of benefits (EOB) forms.
2	We have 30 days from the date we receive your request to: a) Pay the claim (or, if applicable, arrange for the health care provider to give you the care); or b) Write to you to maintain our denial—go to step 4; or c) Ask you or your provider for more information. If we ask your provider, we will send you a copy of our request—go to step 3.
3	You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days. If we do not receive the requested information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.
4	If you do not agree with our decision, you may ask OPM to review it. You must write to OPM within: • 90 days after the date of our letter upholding our initial decision; or • 120 days after you first wrote to us if we did not answer that request in some way within 30 days; or • 120 days after we asked for additional information. Write to OPM at: Office of Personnel Management, Office of Insurance Programs, Contracts Division 3, 1900 E Street, NW, Washington, DC 20415-3630. Send OPM the following information: • A statement about why you believe our decision is wrong, based on specific benefit provisions in this brochure; • Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms; • Copies of all letters you sent us about the claim; • Copies of all letters we sent you about the claim; and • Your daytime phone number and the best time to call. Note: If you want OPM to review different claims, you must clearly identify which documents apply to which claim.

4 (cont.) Note: You are the only person who has a right to file a disputed claim with OPM. Parties acting as your representative, such as medical providers, must include a copy of your specific written consent with the review request.

Note: the above deadlines may be extended if you show that you were unable to meet the deadline because of reasons beyond your control.

5 OPM will review your disputed claim request and will use the information it collects from you and us to decide whether our decision is correct. OPM will send you a final decision within 60 days. There are no other administrative appeals.

6 If you do not agree with OPM's decision, your only recourse is to sue. If you decide to sue, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services, drugs or supplies or from the year in which you were denied precertification or prior approval. This is the only deadline that may not be extended.

OPM may disclose the information it collects during the review process to support their disputed claim decision. This information will become part of the court record.

You may not sue until you have completed the disputed claims process. Further, Federal law governs your lawsuit, benefits, and payment of benefits. The Federal court will base its review on the record that was before OPM when OPM made its decision on your claim. You may recover only the amount of benefits in dispute.

Note: If you have a serious or life-threatening condition (one that may cause permanent loss of bodily functions or death if not treated as soon as possible), and

a) We haven't responded yet to your initial request for care or preauthorization/prior approval, then call us at (800) 431-1211 and we will expedite our review; or

b) We denied your initial request for care or preauthorization/prior approval, then;

- If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim expedited treatment too, or
- You can call OPM's health benefits Contract Division 3 at (202) 606-0755 between 8 a.m. and 5 p.m. Eastern time.

Section 9. Coordinating benefits with other coverage

When you have other health coverage

You must tell us if you or a family member is covered under another group health plan or have automobile insurance that pays health care expenses without regard to fault. This is called double coverage.

When you have double coverage, one plan normally pays its benefits in full as the primary payer and the other plan pays a reduced benefit a the secondary payer. We, like other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners' Guidelines.

When we are the primary payer, we will pay the benefits described in this brochure.

When we are the secondary payer, we will determine our allowance. After the primary plan pays, we will pay what is left of our allowance, up to our regular benefit. We will not pay more than our allowance.

What is Medicare?

Medicare is a Health Insurance Program for:

- People 65 years of age and older.
- Some people with disabilities, under 65 years of age.
- People with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant).

Medicare has two parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free Part A insurance. (Someone who was a Federal employee on January 1, 1983 or since automatically qualifies.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1-800-MEDICARE for more information.
- Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Par B premiums are withheld from your monthly Social Security check or your retirement check.

If you are eligible for Medicare, you may have choices in how you get your health care. Medicare + Choice is the term used to describe the various health plan choices available to Medicare beneficiaries. The information in the next few pages shows how we coordinate benefits with Medicare, depending on the type of Medicare managed care plan you have.

The Original Medicare Plan (Part A or Part B)

The Original Medicare Plan (Original Medicare) is available everywhere in the United States. It is the way everyone used to get Medicare benefits and is the way most people get their Medicare Part A and Part B benefits now. You may go to any doctor, specialist, or hospital that accepts Medicare. Medicare pays its share and you pay your share. Some things are not covered under Original Medicare, like prescription drugs.

When you are enrolled in Original Medicare, you still need to follow the rules in this brochure for us to cover your care. Your care must continue to be authorized by your Plan doctor.

The following chart illustrates whether Original Medicare or this Plan should be the primary payer for you according to your employment status and other factors determined by Medicare. It is critical that you tell us if you or a covered family member has Medicare coverage so we can administer these requirements correctly.

Primary Payer Chart		
A. When either you – or your covered spouse – are age 65 and over and…	**Then the primary payer is…**	
	Original Medicare	**This Plan**
1) Are an active employee with the Federal government (including when you or a family member are eligible for Medicare solely because of a disability),		✓
2) Are an annuitant,	✓	
3) Are a reemployed annuitant with the Federal government when… a) The position is excluded from FEHB, or b) The position is not excluded from FEHB (Ask you employing office which of these applies to you.)	✓	✓
4) Are a Federal judge who retired under title 28, U.S.C., or a Tax Court judge who retired under Section 7447 of title 26, U.S.C. (or if your covered spouse is this type of judge),	✓	
5) Are enrolled in Part B only, regardless of your employment status,	✓ for Part B services	✓ for other services
6) Are a former Federal employee receiving Workers' Compensation and the Office of Workers Compensation Programs determined that you are unable to return to duty,	✓ except claims related to Worker's Compensation	
B. When you – or a covered family member – have Medicare based on end stage renal disease (ESRD) and…		
1) Are within the first 30 months of eligibility to receive Part A benefits solely because of ESRD,		✓
2) Have completed the 30-month ESRD coordination period and are still eligible for Medicare due to ESRD,	✓	
3) Become eligible for Medicare due to ESRD after Medicare became primary for you under another provision,	✓	
C. When you or a covered family member have FEHB and…		
1) Are eligible for Medicare based on disability, and a) Are an annuitant, or	✓	
b) Are an active employee, or		✓
c) Are a former spouse of an annuitant, or	✓	
d) Are a former spouse of an active employee		✓

Claims process when you have the Original Medicare Plan —You probably will never have to file a claim form when you have both our Plan and the Original Medicare Plan.

- When we are the primary payer, we process the claim first.
- When Original Medicare is the primary payer, Medicare processes your claim first. In most cases, your claims will be coordinated automatically and we will pay the balance of covered charges. You will not need to do anything. To find out if you need to do something about filing your claims, call us at (800) 431-1211.

Medicare managed care plan

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a type of Medicare+Choice plan called a Medicare managed care plan. These are health care choices (like HMOs) in some areas of the country. In most Medicare managed care plans, you can only go to doctors, specialists, or hospitals that are part of the plan. Medicare managed care plans provide all the benefits that Original Medicare covers. Some cover extras, like prescription drugs. To learn more about enrolling in a Medicare managed care plan, contact Medicare at 1-800-MEDICARE (1-800-633-4227) or at www.medicare.gov. If you enroll in a Medicare managed care plan, the following options are available to you:

This Plan and another plan's Medicare managed care plan: You may enroll in another plan's Medicare managed care plan and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare managed care plan is primary, even out of the managed care plan's network and/or service area (if you use our Plan providers), but we will not waive any of our copayments or coinsurance. If you enroll in a Medicare managed care plan, tell us. We will need to know whether you are in the Original Medicare Plan or in a Medicare managed care plan so we can correctly coordinate benefits with Medicare.

Suspended FEHB coverage to enroll in a Medicare managed care plan: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a Medicare managed care plan, eliminating your FEHB premium. (OPM does not contribute to your Medicare managed care plan premium). For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next open season unless you involuntarily lose coverage or move out of the Medicare managed care plan's service area.

If you do not enroll in Medicare Part A or Part B

If you do not have one or both Parts of Medicare, you can still be covered under the FEHB Program. We will not require you to enroll in Medicare Part B and, if you can't get premium-free Part A, we will not ask you to enroll in it.

TRICARE

TRICARE is the health care program for eligible dependents of military persons and retirees of the military. TRICARE includes the CHAMPUS program. If both TRICARE and this Plan cover you, we are the primary payer. See your TRICARE Health Benefits Advisor if you have questions about TRICARE coverage.

Workers' compensation

We do not cover services that:

- You need because of a workplace-related illness or injury that the Office of Workers' Compensation Programs (OWCP) or a similar Federal or State agency determine they must provide; or
- OWCP or a similar agency pays for through a third party injury settlement or other similar proceeding that is based on a claim you filed under OWCP or similar laws.

Once the OWCP or similar agency pays its maximum benefits for your treatment, we will cover your care. You must use our providers.

Medicaid

We pay first if both Medicaid and this Plan cover you.

When other Government agencies are responsible for your care

We do not cover services and supplies when a local, State, or Federal Government agency directly or indirectly pays for them.

When others are responsible for injuries

When you receive money to compensate you for medical or hospital care for injuries or illness caused by another person, you must reimburse us for any expenses we paid. However, we will cover the cost of treatment that exceeds the amount you received in the settlement.

If you do not seek damages you must agree to let us try. This is called subrogation. If you need more information, contact us for our subrogation procedures.

Section 10. Definitions of terms we use in this brochure

Calendar year	January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.
Copayment	A copayment is a fixed amount of money you pay when you receive covered services. See page 12.
Coinsurance	Coinsurance is the percentage of our allowance that you must pay for your care. See page 12.
Covered services	Care we provide benefits for, as described in this brochure.
Custodial care	Custodial care means the services which do not need the technical skills or professional training of medical and/or nursing personnel in order to be safely and effectively performed. Examples of custodial care are helping with activities of daily living, giving of oral medications, assistance in walking, turning and positioning in bed, and acting as a companion.
Experimental or investigational services	A drug or device is considered experimental if it does not have the approval for marketing from the U.S. Food and Drug Administration. A drug, device, treatment or procedure is considered experimental or investigational if published reports or written protocols show that it is undergoing clinical trials or is otherwise under study to determine dosage, toxicity or safety.
Group health coverage	Health coverage purchased by an employer, association, union or other organization for its employees or members and their eligible dependents.
Medical necessity	Medical necessity means the most appropriate level of health care services and supplies needed for your treatment. You should receive the right care for your health problem that is common for physicians to give to patients.
Us/We	Us and we refer to PersonalCare
You	You refers to the enrollee and each covered family member

Section 11. FEHB Facts

No pre-existing condition limitation

We will not refuse to cover the treatment of a condition that you or a family member had before you enrolled in this Plan solely because you had the condition before you enrolled.

Where you can get information about enrolling in the FEHB Program

See **www.opm.gov/insure**. Also, your employing or retirement office can answer your questions, and give you a *Guide to Federal Employees Health Benefits Plans*, brochures for other plans and other materials you need to make an informed decision about:

- When you may change your enrollment;
- How you can cover your family members;
- What happens when you transfer to another Federal agency, go on leave without pay, enter military service, or retire;
- When your enrollment ends; and
- When the next open season for enrollment begins.

We don't determine who is eligible for coverage and, in most cases, cannot change your enrollment status without information from your employing or retirement office.

Types of coverage available for you and your family

Self-Only coverage is for you alone. *Self and Family* coverage is for you, your spouse, and your unmarried dependent children under age 22, including any foster or step children your employing or retirement office authorizes coverage for. Under certain circumstances, you may also get coverage for a disabled child 22 years of age or older who is incapable of self-support.

If you have a Self Only enrollment, you may change to a Self and Family enrollment if you marry, give birth or add a child to your family. You may change your enrollment 31 days before to 60 days after you give birth or add the child to your family. The benefits and premiums for your Self and Family enrollment begin on the first day of the pay period in which the child is born or becomes an eligible family member. When you change to Self and Family because you marry, the change is effective on the first day of the pay period that begins after your employing office receives your enrollment form; benefits will not be available to your spouse until you marry.

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive health benefits, nor will we. Please tell us immediately when you add or remove family members from your coverage for any reason, including divorce, or when your child under age 22 marries or turns 22.

If you or one of your family members is enrolled in one FEHB plan, that person may not be enrolled in or covered as a family member by another FEHB plan.

When benefits and premiums start

The benefits in this brochure are effective on January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

Your medical and claims records are confidential

We will keep your medical and claims information confidential. Only the following will have access to it:

- OPM, this Plan, and subcontractors when they administer this contract,
- This Plan and appropriate third parties, such as other insurance plans and the Office of Workers' Compensation Programs (OWCP), when coordinating benefit payments and subrogating claims,
- Law enforcement officials when investigating and/or prosecuting alleged civil or criminal actions,
- OPM and the General Accounting Office when conducting audits,
- Individuals involved in bona fide medical research or education that does not disclose your identity; or
- OPM, when reviewing a disputed claim or defending litigation about a claim.

When you retire

When you retire, you can usually stay in the FEHB Program. Generally, you must have been enrolled in the FEHB Program for the last five years of your Federal service. If you do not meet this requirement, you may be eligible for other forms of coverage, such as temporary continuation of coverage (TCC).

When you lose benefits

- **When FEHB coverage ends**

You will receive an additional 31 days of coverage, for no additional premium, when:

- Your enrollment ends, unless you cancel your enrollment, or
- You are a family member no longer eligible for coverage.

You may be eligible for former spouse coverage or Temporary Continuation of Coverage.

- **Spouse equity coverage**

If you are divorced from a Federal employee or annuitant, you may not continue to get benefits under your former spouse's enrollment. But, you may be eligible for your own FEHB coverage under the spouse equity law. If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get RI 70-5, the *Guide to Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees*, or other information about your coverage choices.

- **TCC**

If you leave Federal service or if you lose coverage because you no longer qualify as a family member, you may be eligible for TCC. For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your job, if you are a covered dependent child and you turn 22 or marry, etc.

You may not elect TCC if you are fired from your Federal job due to gross misconduct.

Enrolling in TCC. Get the RI 79-27, which describes TCC, and the RI 70-5, the *Guide to Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees* from your employing or retirement office or from **www.opm.gov/insure** . It explains what you have to do to enroll.

- **Converting to individual coverage**

You may convert to a non-FEHB policy if:

- Your coverage under TCC or the spouse equity law ends (Iou canceled your coverage or did not pay your premium, you cannot convert);
- You decided not to receive coverage under TCC or the spouse equity law; or
- You are not eligible for coverage under TCC or the spouse equity law.

If you leave Federal service, your employing office will notify you if individual coverage is available. You must apply in writing to us within 31 days after you receive this notice. However, if you are a family member who is losing coverage, the employing or retirement office will not notify you. You must apply in writing to us within 31 days after you are no longer eligible for coverage.

Your benefits and rates will differ from those under the FEHB Program; however, you will not have to answer questions about your health, and we will not impose a waiting period or limit your coverage due to pre-existing conditions.

Getting a Certificate of Group Health Plan Coverage

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a Federal law that offers limited Federal protections for health coverage availability and continuity to people who lose employer group coverage. If you leave the FEHB Program, we will give you a Certificate of Group Health Plan Coverage that indicates how long you have been enrolled with us. You can use this certificate when getting health insurance or other health care coverage. Your new plan must reduce or eliminate waiting periods, limitations or exclusions for health related conditions based on the information in the certificate. You must arrange for the other coverage within 63 days of leaving this Plan. If you have been enrolled with us for less than 12 months, but were previously enrolled in other FEHB plans, you may also request a certificate from those plans.

For more information, get OPM pamphlet RI 79-27, Temporary Continuation of Coverage (TCC) under the FEHB Program. See also the FEHB web site (www.opm.gov/insure/health); refer to the "TCC and HIPAA" frequently asked question. These highlight HIPAA rules, such as the requirement that Federal employees must exhaust any TCC eligibility as one condition for guaranteed access to individual health coverage under HIPAA, and have information about Federal and State agencies you can contact for more information.

Long Term Care Insurance Is Coming Later in 2002!

- Many FEHB enrollees think that their health plan and/or Medicare will cover their long-term care needs. Unfortunately, they are *WRONG*!
- How are YOU planning to pay for the future custodial or chronic care you may need?
- You should consider buying long-term care insurance.

The Office of Personnel Management (OPM) will sponsor a high-quality long term care insurance program effective in October 2002. As part of its educational effort, OPM asks you to consider these questions:

What is long term care (LTC) insurance?

- It's insurance to help pay for long term care services you may need if you can't take care of yourself because of an extended illness or injury, or an age-related disease such as Alzheimer's.
- LTC insurance can provide broad, flexible benefits for nursing home care, care in an assisted living facility, care in your home, adult day care, hospice care, and more. *LTC insurance can supplement care provided by family members, reducing the burden you place on them*.

I'm healthy. I won't need long term care. Or, will I?

- Welcome to the club!
- 76% of Americans believe they will never need long term care, but the facts are that about half of them will. And it's not just the old folks. About 40% of people needing long term care are under age 65. They may need chronic care due to a serious accident, a stroke, or developing multiple sclerosis, etc.
- We hope you will never need long term care, but everyone should have a plan just in case. *Many people now consider long term care insurance to be vital to their financial and retirement planning.*

Is long term care expensive?

- Yes, it can be very expensive. A year in a nursing home can exceed $50,000. Home care for only three 8- hour shifts a week can exceed $20,000 a year. And that's before inflation!
- Long term care can easily exhaust your savings. *Long term care insurance can protect your savings.*

But won't my FEHB plan, Medicare or Medicaid cover my long term care?

- Not FEHB. Look at the "*Not covered*" blocks in sections 5(a) and 5(c) of your FEHB brochure. Health plans don't cover custodial care or a stay in an assisted living facility or a continuing need for a home health aide to help you get in and out of bed and with other activities of daily living. Limited stays in skilled nursing facilities can be covered in some circumstances.
- Medicare only covers skilled nursing home care (the highest level of nursing care) after a hospitalization for those who are blind, age 65 or older or fully disabled. It also has a 100 day limit.
- Medicaid covers long term care for those who meet their state's poverty guidelines, but has restrictions on covered services and where they can be received. *Long term care insurance can provide choices of care and preserve your independence.*

When will I get more information on how to apply for this new insurance coverage?

- Employees will get more information from their agencies during the LTC open enrollment period in the late summer/early fall of 2002.
- Retirees will receive information at home.

How can I find out more about the program NOW?

- Our toll-free teleservice center will begin in mid-2002. In the meantime, you can learn more about the program on our web site at www.opm.gov/insure/ltc.

Index

Do not rely on this page; it is for your convenience and may not show all pages where the terms appear.

Summary of benefits for PersonalCare HMO - 2002

- **Do not rely on this chart alone.** All benefits are provided in full unless indicated and are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.
- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.
- We only cover services provided or arranged by Plan physicians, except in emergencies.

Benefits	You pay	Page
Medical services provided by physicians:		
• Diagnostic and treatment services provided in the office	Office visit copay: $10 primary care; $10 specialist	14
Services provided by a hospital:		
• Inpatient	$100 per admission copay	25
• Outpatient	Nothing	26
Emergency benefits:		
• In-area	$50 per visit	28
• Out-of-area	$50 per visit	29
Mental health and substance abuse treatment	Regular cost sharing	30
Prescription drugs	$5 generic, $15 preferred brand, $35 nonpreferred brand	32
Dental Care	No benefit.	35
Vision Care	$30 copay per exam	18
Special Features: Centers of Excellence for Transplants		34
Protection against catastrophic costs (your out-of-pocket maximum)	Nothing after $1,500/Self Only or $3,000/Family enrollment per year Some costs do not count toward this protection	12

2002 Rate Information for PersonalCare's HMO Health Plan

Non-Postal rates apply to most non-Postal enrollees. If you are in a special enrollment category, refer to the FEHB Guide for that category or contact the agency that maintains your health benefits enrollment.

Postal rates apply to career Postal Service employees. Most employees should refer to the FEHB Guide for United States Postal Service Employees, RI 70-2. Different postal rates apply and special FEHB guides are published for Postal Service Nurses, RI 70-2B; and for Postal Service Inspectors and Office of Inspector General (OIG) employees (see RI 70-2IN).

Postal rates do not apply to non-career postal employees, postal retirees, or associate members of any postal employee organization who are not career postal employees. Refer to the applicable FEHB Guide.

		Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
Type of Enrollment	Code	Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share
High Option Self Only	GE1	67.79	22.60	146.89	48.96	80.22	10.17
High Option Self and Family	GE2	174.32	58.11	377.70	125.90	206.28	26.15